		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021493

Facility Name: Apostolic Christian Home

Address: 1102 W. Randolph St. (Number) Roanoke (City) 61561 (Zip Code)

County: Woodford

Telephone Number: 309-923-2071 **Fax #** 309-923-7919

IDPA ID Number: 37-0990253001

Date of Initial License for Current Owners: 05/05/1975

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 C (3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Richard D. Isaia **Telephone Number:** 309-923-2071

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,849	10,858	942	20,649	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,849	10,858	942	20,649	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.29%

D. How many bed-hold days during this year were paid by Public Aid?
5 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Part B Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/05/75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 942

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	188,651	15,893	23,642	228,186		228,186	(5,296)	222,890			1
2	Food Purchase		120,185		120,185		120,185		120,185			2
3	Housekeeping	120,493	(2,827)	657	118,323		118,323		118,323			3
4	Laundry	55,510	4,962	1,098	61,570		61,570		61,570			4
5	Heat and Other Utilities			56,285	56,285		56,285		56,285			5
6	Maintenance	45,401	19,352	33,274	98,027		98,027		98,027			6
7	Other (specify):*		10,435	122,926	133,361		133,361	(133,361)				7
8	**TOTAL General Services**	410,055	168,000	237,882	815,937		815,937	(138,657)	677,280			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,101,502	120,677	49,206	1,271,385	(16,941)	1,254,444		1,254,444			10
10a	Therapy	81,688	1,203	7,353	90,244		90,244		90,244			10a
11	Activities	72,750	16,648	(90)	89,308		89,308		89,308			11
12	Social Services	32,633	1,642	3,598	37,873		37,873		37,873			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,288,573	140,170	60,067	1,488,810	(16,941)	1,471,869		1,471,869			16
	C. General Administration											
17	Administrative	61,540			61,540		61,540		61,540			17
18	Directors Fees											18
19	Professional Services			17,368	17,368		17,368		17,368			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	88,587	13,109	30,106	131,802		131,802		131,802			21
22	Employee Benefits & Payroll Taxes			376,325	376,325		376,325		376,325			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,771	57,771		57,771		57,771			26
27	Other (specify):*											27
28	**TOTAL General Administration**	150,127	13,109	481,570	644,806		644,806		644,806			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,848,755	321,279	779,519	2,949,553	(16,941)	2,932,612	(138,657)	2,793,955			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Home #0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			292,667	292,667		292,667	(97,844)	194,823			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,023	59,023		59,023	(51,445)	7,578			32
33	Real Estate Taxes			21,937	21,937		21,937	(21,937)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			373,627	373,627		373,627	(171,226)	202,401			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			8,875	8,875		8,875		8,875			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* **PHARMACY**					16,941	16,941		16,941			43
44	**TOTAL Special Cost Centers**			41,725	41,725	16,941	58,666		58,666			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,848,755	321,279	1,194,871	3,364,905		3,364,905	(309,883)	3,055,022			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,296)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(51,445)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,741)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(253,142)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (253,142)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (309,883)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs	x		16,941	10	43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 16,941		47

Apostolic Christian Home

ID# 0021493

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Real Estate Taxes	$ (736)	33	1
2	Country View Expenses	(103,772)	7	2
3	Country View Depreciation	(33,863)	30	3
4	Duplex Expenses	(29,589)	7	4
5	Duplex Depreciation	(63,981)	30	5
6	Duplex Real Estate Taxes	(21,201)	33	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(253,142)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Home # 0021493 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,296)	0	0	0	0	0	0	0	0	0	0	(5,296)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(133,361)	0	0	0	0	0	0	0	0	0	0	(133,361)	7
8	**TOTAL General Services**	(138,657)	0	0	0	0	0	0	0	0	0	0	(138,657)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(138,657)	0	0	0	0	0	0	0	0	0	0	(138,657)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Home # 0021493 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(97,844)	0	0	0	0	0	0	0	0	0	0	(97,844)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,445)	0	0	0	0	0	0	0	0	0	0	(51,445)	32
33	Real Estate Taxes	(21,937)	0	0	0	0	0	0	0	0	0	0	(21,937)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(171,226)	0	0	0	0	0	0	0	0	0	0	(171,226)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(309,883)	0	0	0	0	0	0	0	0	0	0	(309,883)	45

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MORTON COMMUNITY	X		WORKING CAPITAL	VARIOUS	VAR.	ZERO	200,000	VARIOUS	4.2500	7,578	6
7	BANK											7
8												8
9	TOTAL Facility Related						$	$ 200,000			$ 7,578	9
	B. Non-Facility Related*											
10	COMMERCE BANK		X	CNTRY VIEW BLDG LOAN	$7,800.00	3/28/00	875,000	727,984	2/10/15	6.8500	51,445	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$7,800.00		$ 875,000	$ 727,984			$ 51,445	14
15	TOTALS (line 9+line14)						$ 875,000	$ 927,984			$ 59,023	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** NONE **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

ALL REAL ESTATE TAXES ARE NON-ALLOWABLE AND ARE ADJUSTED OUT OF SCHEDULE V

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Home COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0021493

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$ NONE
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,601 B. General Construction Type: Exterior Brick Frame Block & Wood Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apostolic Christian Home of Roanoke Duplexes - 12 units

Apostolic Christian Home of Roanoke Country View Apartments (Independent Living Units) 14 - units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building & Grounds	100,000	1975	$ 35,875	1
2					2
3	TOTALS	100,000		$ 35,875	3

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1975	1958	$ 202,000	$		$	$	$	4
5			1976	1976	22,708	5,638	30	5,638		219,070	5
6			1991	1991	671,286	22,376	30	22,376		270,377	6
7			1992	1992	129,607	4,469	30	4,469		51,393	7
8											8
	Improvement Type**										
9	LAND & BLDG IMPROVEMENTS			1976	105,004						9
10				1977	6,591						10
11				1978	10,960						11
12				1979	9,124						12
13				1980	8,166						13
14				1981	6,506						14
15				1982	18,087						15
16				1983	36,023						16
17				1984	12,947						17
18				1985	13,333	8,617	VARIOUS	8,617		565,629	18
19				1986	8,595						19
20				1987	87,248						20
21				1988	43,526						21
22				1989	64,604						22
23				1990	11,217						23
24				1991	3,700						24
25				1992	5,410						25
26				1993	36,135						26
27				1994	14,661						27
28				1995	30,372						28
29	SOILED UTILITY REMODELING			1996	680	97	7	97		631	29
30	FIXED TV MONITORING SYSTEM			1996	278	40	7	40		259	30
31	REMODEL 14 EAST			1996	2,781	397	7	397		2,581	31
32	NEW SIDEWALK			1996	1,375	196	7	196		1,275	32
33	ROOM REMODELING (9,21,17)			1997	11,487	1,641	7	1,641		10,666	33
34	ROOM REMODELING (11,8,10,19,5,6)			1997	17,049	2,436	7	2,436		15,833	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIRE ALARM SYSTEM COSTS	1998	$ 12,671	$ 1,810	7	$ 1,810	$	$ 9,955	37
38	ROOM REMODELING (3, 12, 14)	1998	13,953	1,993	7	1,993		10,962	38
39	GAS LINE WORK	1998	1,033	147	7	147		809	39
40	PARKING LOT	1998	19,397	2,771	7	2,771		15,240	40
41	COURTYARD	1998	15,971	2,282	7	2,282		12,550	41
42	FIRE ALARM SYSTEM COSTS	1999	87,698	12,528	7	12,528		56,376	42
43	CALL LIGHT SYSTEM COSTS	1999	40,500	5,785	7	5,785		26,033	43
44	EAST ROOM REMODELING	1999	23,345	3,335	7	3,335		15,007	44
45	PT RESTROOM REMODEL	1999	605	87	7	87		391	45
46	MULTI-PURPOSE ROOM REMODEL	1999	1,438	205	7	205		923	46
47	SPRINKLER SYSTEM ADDITIONS	1999	3,166	452	7	452		2,034	47
48	STROM SEWER WORK	1999	2,396	342	7	342		1,539	48
49	DOOR ALARM SYSTEM	1999	2,075	296	7	296		1,332	49
50	WEST STATION ARCHITECT FEES	1999	4,742	677	7	677		3,047	50
51	EAST SIDE STATIONS REMODELING	2000	43,536	6,219	7	6,219		21,766	51
52	WEST SIDE STATION	2000	4,637	662	7	662		2,317	52
53	CALL LIGHT SYSTEM COSTS	2000	11,500	1,643	7	1,643		5,750	53
54	DOOR ALARM SYSTEM REMODEL	2000	2,093	299	7	299		1,046	54
55	RESIDENT ROOM REMODEL	2000	7,066	1,009	7	1,009		3,532	55
56	LANDSCAPING	2000	3,152	630	7	630		2,205	56
57	WATER MAIN EXTENSION	2000	1,675	335	7	335		1,172	57
58	SPRINKLER WORK	2001	19,622	2,803	7	2,803		7,007	58
59	NURSING AND SOCIAL SERVICE OFFICES	2001	1,587	227	7	227		567	59
60	NEW PARKING AREA	2001	2,363	337	7	337		843	60
61	ROOM REMODELING (12W)	2001	2,612	373	7	373		932	61
62	NEW WATER LINES	2001	4,581	654	7	654		1,635	62
63	ROOM REMODELED (8W)	2001	3,422	488	7	488		1,220	63
64	TUB ROOM ROOF	2001	27,941	3,992	7	3,992		9,980	64
65	WEST TUB REMODEL	2001	25,454	3,636	7	3,636		9,090	65
66	EAST HALL REMODEL	2001	23,052	3,293	7	3,293		8,233	66
67	EAST PARK AREA	2001	1,687	337	7	337		843	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,006,430	$ 105,554		$ 105,554	$	$ 1,372,050	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,006,430	$ 105,554		$ 105,554	$	$ 1,372,050	1
2	VINYL FLOORING - HSKG	2002	1,001	143	7	143		215	2
3	NURSING OFFICE	2002	1,068	152	7	152		228	3
4	EAST HALL REMODEL	2002	12,749	1,821	7	1,821		2,732	4
5	DELAYED EGRESS LOCK	2002	1,934	276	7	276		414	5
6	ROOM 5 REMODEL	2002	2,999	428	7	428		642	6
7	ROOM REMODEL	2002	3,173	453	7	453		680	7
8	WATER LINE REPAIRS	2002	15,959	2,280	7	2,280		3,420	8
9	TUB ROOM REMODEL	2002	235,862	33,695	7	33,695		50,542	9
10	WEST NURSE STATION	2003	21,472	1,534	7	1,534		1,534	10
11	WATER LINE REPAIRS	2003	4,424	316	7	316		316	11
12	ROOM REMODEL - 2 ROOMS	2003	3,808	272	7	272		272	12
13	NORTH CEILING REPAIR	2003	2,980	213	7	213		213	13
14	MIXING VALVES	2003	679	48	7	48		48	14
15	BASEMENT STAIRS	2003	6,956	497	7	497		497	15
16	CANOPY SPRINKLER	2003	1,425	101	7	101		101	16
17	ALARM SYSTEMS	2003	3,017	215	7	215		215	17
18	MECHANICAL ROOM WORK	2003	2,907	207	7	207		207	18
19	SPRINKLER IMPROVEMENT	2003	6,428	459	7	459		459	19
20	LANDSCAPING SIDEWALK	2003	4,741	474	7	474		474	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,340,012	$ 149,138		$ 149,138	$	$ 1,435,259	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 148,803	$ 29,814	$ 29,814	$	5	$ 159,368	71
72	Current Year Purchases	60,232	6,023	6,023		5	6,023	72
73	Fully Depreciated Assets	531,480					531,480	73
74								74
75	TOTALS	$ 740,515	$ 35,837	$ 35,837	$		$ 696,871	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRIPS	FORD 1999	1999	$ 49,239	$ 9,848	$ 9,848	$	5	$ 44,316	76
77										77
78										78
79										79
80	TOTALS			$ 49,239	$ 9,848	$ 9,848	$		$ 44,316	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,165,641	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 194,823	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 194,823	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,176,446	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	GROUNDS - LAND	$ 88,728	$	$	86
87	DUPLEXES	1,613,593	48,615	425,593	87
88	COUNTRY VIEW APARTMENTS	1,092,486	23,187	104,019	88
89	DUPLEX FURN & FIX	304,786	15,366	20,918	89
90	COUNTRY VIEW FURN & FIX	55,199	10,676	32,794	90
91	TOTALS	$ 3,154,792	$ 97,844	$ 583,324	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist	NONE	hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Home **#** 0021493 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 83,753	$	1
2	Cash-Patient Deposits	4,635		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	180,371		3
4	Supply Inventory (priced at)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	20,387		6
7	Other Prepaid Expenses	6,214		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 315,360	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,603		13
14	Buildings, at Historical Cost	5,325,810		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	870,021		16
17	Accumulated Depreciation (book methods)	(2,762,237)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,558,197	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,873,557	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 115,809	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,635		28
29	Short-Term Notes Payable	258,500		29
30	Accrued Salaries Payable	123,214		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,149		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 525,307	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	930,283		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Duplex Equity	1,441,031		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,371,314	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,896,621	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 976,936	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,873,557	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,027,549	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,027,549	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(312,500)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	261,887	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (50,613)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 976,936	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,320,232	1
2	Discounts and Allowances for all Levels	(587,840)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,732,392	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,296	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,296	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	704	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 704	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Country View Income	227,980	28
28a	Duplex Income	86,033	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 314,013	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,052,405	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	815,937	31
32	Health Care	1,488,810	32
33	General Administration	644,806	33
	B. Capital Expense		
34	Ownership	373,627	34
	C. Ancillary Expense		
35	Special Cost Centers	8,875	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,364,905	40
41	**Income before Income Taxes (line 30 minus line 40)****	(312,500)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (312,500)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,893	2,080	$ 52,787	$ 25.38	1
2	Assistant Director of Nursing	1,484	1,660	34,009	20.49	2
3	Registered Nurses	10,057	11,076	231,829	20.93	3
4	Licensed Practical Nurses	6,915	7,476	142,627	19.08	4
5	Nurse Aides & Orderlies	54,113	58,163	640,250	11.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,882	5,286	81,688	15.45	8
9	Activity Director	1,951	2,204	25,857	11.73	9
10	Activity Assistants	5,267	5,646	46,893	8.31	10
11	Social Service Workers	2,883	3,063	32,633	10.65	11
12	Dietician					12
13	Food Service Supervisor	1,849	2,080	31,264	15.03	13
14	Head Cook	6,224	6,626	60,296	9.10	14
15	Cook Helpers/Assistants	12,168	12,923	97,091	7.51	15
16	Dishwashers					16
17	Maintenance Workers	3,086	3,434	45,401	13.22	17
18	Housekeepers	11,322	12,139	95,344	7.85	18
19	Laundry	5,767	6,334	55,510	8.76	19
20	Administrator	1,882	2,080	61,540	29.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,843	7,369	88,587	12.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) HSKP SUP	1,858	2,080	25,149	12.09	33
34	TOTAL (lines 1 - 33)	140,444	151,719	$ 1,848,755 *	$ 12.19	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	0	$ 0		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard D. Isaia	Administrator	None	$ 61,540
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 61,540

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Bob Rein - CPA	Accounting Services	$ 2,006
Heinold - Banwart	Accounting Services	2,978
Health Outcomes Management	Computer Services	7,740
Michael Arends	Computer Services	287
Mike Gray	Computer Services	450
Route 24 Computers	Computer Services	3,907
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 17,368

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,392
Unemployment Compensation Insurance	4,313
FICA Taxes	136,416
Employee Health Insurance	149,204
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 376,325

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Expenses for background checks are in Line 10 Column C Nursing Misc.	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Home # 0021493 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2	NONE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Home **#** 0021493 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN $2,229 AAHSA $739**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,927** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **NO** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **32,850**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **5,296**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.